ENTEROVIRUS D68 (EV-D68) PATIENT SUMMARY FORM

Today's date:

This form is to be completed for all patients for whom specimens have been/are being submitted to CDC for EV-D68 typing. As soon as possible, please fax this completed form to the state health department at (304)-558-8736.

Name of person filling in form:	Phone Number:
Hospital/Facility Name:	Email:
County:	State:

PATIENT INFORMATION

Name:	Sex: ☐M ☐F	Date of birth:
County of residence:	Ethnicity: ☐Hispanic ☐Non-Hispanic	

Race: ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Asian
☐American Indian or Alaska Native ☐White ☐Other:

Date of symptom onset:	Fever? ☐Y ☐N *Highest recorded temperature:* °F

Check all that apply:

☐Chills ☐Cough ☐Wheezing ☐Sore Throat ☐Shortness of breath
☐Runny nose ☐Tachypnea ☐Retractions ☐Cyanosis ☐Vomiting
☐Diarrhea ☐Rash ☐Lethargy ☐Seizure ☐Other: _____

Does the patient have any comorbid conditions (mark all that apply)?

☐Asthma ☐Reactive airway disease ☐Bronchopulmonary dysplasia ☐Immunocompromised
☐Cardiac disease ☐Prematurity (age): ☐Other: ☐Unknown

Does the patient have: Abnormal chest radiograph? ☐Y ☐N Abnormal chest CT? ☐Y ☐N

Is/was the patient:	Yes	No	Unknown
Hypoxic (saturation <93% on room air)?	☐	☐	☐
Treated with supplemental oxygen?	☐	☐	☐
Treated with bronchodilators?	☐	☐	☐
Treated with antibiotics?	☐	☐	☐
Hospitalized? If yes, admission date: _____	☐	☐	☐
If hospitalized (mark all that apply): ☐Admitted to ICU ☐Intubated ☐Placed on BiPAP/CPAP ☐Placed on ECMO			
Did the patient die? If yes, date of death:	☐	☐	☐

LABORATORY TESTING

	RESULT					RESULT			
Pathogen	+	-	Pending	Not Done	Pathogen	+	-	Pending	Not Done
Influenza A PCR	☐	☐	☐	☐	Rhinovirus/Enterovirus	☐	☐	☐	☐
Influenza B PCR	☐	☐	☐	☐	Coronavirus (not MERS-CoV)	☐	☐	☐	☐
Influenza Rapid Test	☐	☐	☐	☐	*Chlamydophila pneumonia*	☐	☐	☐	☐
RSV	☐	☐	☐	☐	*Mycoplasma pneumoniae*	☐	☐	☐	☐
Human metapneumovirus	☐	☐	☐	☐	*Legionella pneumophila*	☐	☐	☐	☐
Parainfluenza virus	☐	☐	☐	☐	*Streptococcus pneumonia*	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐	Blood culture:	☐	☐	☐	☐
Other:	☐	☐	☐	☐	CSF culture:	☐	☐	☐	☐
Other:	☐	☐	☐	☐	Sputum culture:	☐	☐	☐	☐

Enterovirus Typing Specimen	Date Collected	Specimen ID	Enterovirus Typing Specimen	Date Collected	Specimen ID
(mark one) ☐NP ☐OP ☐NP/OP			Bronchoalvelolar lavage (BAL)		
Nasal wash/aspirate			Tracheal aspirate		
Sputum			Stool/Rectal swab		
Other:			Other:		

(To be completed by state health department) Hospital ID: State ID:
(To be completed by CDC) Patient ID: CSID: CSID: CSID: CSID: